

GROUP PRACTICE INTEGRATION IN LIGHT OF PPACA AND STARK

Adrienne Dresevic, Esq.
Carey F. Kalmowitz, Esq.
THE HEALTH LAW PARTNERS, P.C.

PPACA and Payment Reform

As is known to those industry stakeholders that remain attentive to the dynamic changes in the health care landscape, within the provisions of the Patient Protection and Affordable Care Act (“PPACA”), there are two important payment reform provisions which are triggering a wave of new or modified legal structures, all of which focus on clinical integration among physicians, hospitals and other health care providers and suppliers. Section 3022 of PPACA establishes a shared savings program pursuant to which Medicare will share cost savings for high quality care delivered by an accountable care organization (“ACO”) to Medicare beneficiaries in its traditional fee-for-service program (the “Shared Savings Program”). Section 3023 of PPACA, establishes a nationwide pilot program designed to support the policies of making all providers of health care responsible during an episode of care and rewarding *value* over volume with incentives for providers to coordinate patient care across the continuum of an entire episode of care (the “Payment Bundling Program Pilot”). However, to take advantage of the financial incentives resulting from the Shared Savings Program and the Payment Bundling Program Pilot, all health care providers and suppliers along the full continuum of care must form new (or modify) legal structures that align interests and reward quality outcomes over volume. Although there are many new legal structures and alliances that are currently in various stages of maturity (which go significantly beyond more traditional organizations such as PHOs or IPAs), this article will solely focus on a growing trend that has emerged in the authors’ practice experience; the merger-like transactions of existing physician group practices into larger group practices that are preparing for the dramatic transformation in the way health care is delivered and how payments will be made.

Specifically, with respect to the Shared Savings Program’s use of ACOs, PPACA does not mandate a specific legal structure for an ACO. Instead, an eligible ACO means a group of providers and suppliers who, among others, can demonstrate:

1. A formal, legal structure that allows the ACO to receive and distribute payments for shared savings to participating providers of services and suppliers.
2. An established mechanism for joint decision making.
3. A leadership and management structure that includes clinical and administrative systems.
4. Clinical information systems sufficient to satisfy quality and other reporting requirements and to determine payments for shared savings.
5. Established processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.
6. Sufficient primary care physicians for the number of Medicare fee-for-service beneficiaries which it will be assigned.

Thus, an ACO, for example, may constitute a private practice comprised of physicians, regardless of specialty in group practice structures. Further, the Payment Bundling Program Pilot will necessarily involve payment arrangements among various health care providers on the backside of the bundled payment which means that various regulatory hurdles will exist, including ensuring that the legal structure and/or various financial relationships among the health care providers and suppliers comply with the Federal Stark law (“Stark”). Importantly, with respect to physician group practice arrangements, the various compensation relationships and integration issues within the group practice must be carefully analyzed to ensure compliance with the Stark group practice definition (the “Stark Group Practice Definition”). Some of the important Stark Group Practice Definition issues are summarized below.

The Stark Group Practice Definition and Integration

By way of brief overview, generally, a physician is prohibited from referring Medicare (and under Michigan law, all source of payments) patients for designated health services (“DHS”) where the physician has a financial relationship, unless an exception applies which will permit such referrals. The most prominent exception which allows physicians and group practices to refer within their offices for DHS is the in-office ancillary services exception. A key factor, however, in meeting the in-office ancillary services exception is ensuring compliance with the Stark Group Practice Definition. The Stark Group Practice Definition contains many elements, but physicians often tend to focus only on the rules relating to the distribution of profits and compensation of the physicians of the group. However, now more than ever, one very important element which must be carefully scrutinized by groups, and which is often overlooked by physicians, is what is called the “unified business test.”

The unified business test is intended to ensure that a group practice is organized and operated on a bona fide basis as a single integrated business enterprise with legal and organizational integration. Although Stark does not prescribe particular processes for achieving integration, it allows a group to divide into separate divisions, but demands significant “group level” management and operation. To meet this requirement, the governing board of the group practice must exercise substantial control over all of its operation, including the operation of separate divisions, and not simply act to “rubber stamp” decisions.

Specifically, the “unified business test” requires that the group have at least the following features: (i) Centralized decision-making by a body representative of the group practice that maintains effective control over the group's assets and liabilities (including, but not limited to, budgets, compensation, and salaries); and (ii) Consolidated billing, accounting, and financial reporting. Notably, a group practice can establish certain location and specialty-based compensation practices (as long as there are at least five (5) physicians) and remain compliant with the “unified business test”. The group, however, must ensure that such location and specialty-based compensation practices are designed in accordance with the special rules on compensation set forth in the Stark Group Practice Definition. Notwithstanding Stark’s permissibility of these special group subsets, caution and careful review should be undertaken by group practices and they should not be interpreted as providing a vehicle to circumvent Stark’s prohibition on allowing group practice physicians from “directly” profiting from their DHS referrals. Thus, subgroups comprising five (5) physicians should not be established solely based on the volume or value of referrals made by them to the group practice. It is possible to adopt a

center-like approach to group practices, and to allow each so-called center to make certain decisions about compensating physicians within the center, but, these decisions must be reviewed and approved by the group practice's governing body (and, as noted above, the governing body should not be simply "rubber stamping" the decisions of the centers).

Because of PPACA's payment reforms, it is now increasingly more imperative that group practices implement policies that will assist the group with achieving complete integration, as any expansion or merger-like transaction that the group practice undertakes could significantly magnify any current integration concerns, making it very difficult to address as the group expands to prepare for future transformations in health care delivery and payment under PPACA.